ELEGANT RATIONAL-EMOTIVE BEHAVIOUR THERAPY (REBT) AND HYPNOSIS: IS AN ELEGANT COMBINATION FEASIBLE AND BENEFICIAL?

(A THEORETICAL DISSERTATION)

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Introduction

Psychologist Albert Ellis, Ph.D. first articulated the principles of Rational Emotive Behaviour Therapy (REBT) in 1955. According to REBT theory at the core of emotional disturbance of humans is a biological tendency to transform desires, wants and preferences into rigid, dogmatic and absolute beliefs. Ellis differentiates between elegant and inelegant approaches to therapy and considers hypnotherapy as an inelegant approach.

Hypnotherapy is a popular and well known form of therapy. Research has demonstrated its many clinical applications. Hypnosis however is not therapy, rather hypnotherapy is the use of hypnosis in a therapeutic setting. How hypnosis is conceptualised determines its use and application within a therapeutic setting.

This dissertation attempts to examine the use of hypnosis in REBT and whether it can be elegant. It will define elegant and inelegant REBT practice, discuss some of the many definitions of hypnosis and ascertain which of these definitions Ellis appears to advocate in order to understand why he regards hypnosis as inelegant. In response this dissertation will question the validity of his perspective.

It is likely that some REBT practitioners may have clients requesting hypnosis and some hypnotherapists trained in REBT may be interested in working within an elegant framework.
This dissertation will attempt to highlight the benefits of using hypnosis with REBT so that clients in an REBT setting are not dissuaded from seeking hypnotherapy and in converse hypnotherapists can be confident that they can work in an elegant manner.
Albert Ellis' REBT

Psychologist Albert Ellis, Ph.D. first articulated the principles of Rational Emotive Behaviour Therapy (REBT) in 1955. Albert Ellis was born in 1913 in Pittsburgh, Pennsylvania, but moved to New York at age 4. He was hospitalized numerous times during childhood, and suffered renal glycosuria at age 19 and diabetes at age 40. Because Ellis has suffered from these ailments for most of his life, his problems have inspired him over the years to find effective means of coping. Ellis originally studied psychoanalysis and believed it to be the deepest form of psychotherapy. But later he came to the conclusion that analytical and dynamic psychotherapies are unscientific. He became dissatisfied with them as effective and efficient forms of treatment. In 1955 he combined humanistic, philosophical, and behaviour therapies to form what is now known as REBT. Today he is one of the world’s most influential psychologists and prolific authors.

REBT or Rational Therapy (RT) as it was known up to 1961, or Rational Emotive Therapy (RET) as it was known up to 1993 is a ‘particular conception of unhealthy and healthy psychological functioning including the methods required to reduce the former and increase the latter’ (Dryden & Neenan, 1996).

REBT is an action-oriented humanistic approach to emotional growth that stresses individuals’ capacity for creating, altering, and controlling their emotional states.
REBT places much emphasis on the present - on currently held beliefs and attitudes, painful emotions, and maladaptive/dysfunctional behaviours that can sabotage a fuller experience of life. That is, REBT teaches people how to overcome problems and how to implement gratifying and realistic alternatives to current psychological patterns.

Ellis generally defines the client’s problems from the therapist’s framework (using “formal” rather than “informal” characterisations of the problem). So practitioners work closely with their clients, seeking to help uncover their individual set of beliefs (attitudes, expectations and personal rules) that frequently lead to emotional distress.

According to REBT theory at the core of emotional disturbance of humans is a biological tendency to transform desires, wants and preferences into rigid, dogmatic and absolute beliefs. These take the form of musts, shoulds, ought to’s, have to’s and got to’s, e.g. the anxiety producing belief ‘I must pass my driving test’. Flowing from these absolutists beliefs are three major derivatives, awfulising; an unrealistic assessment of badness where negative events are viewed or defined as end of the world bad or more than 101% bad, e.g. ‘it would be awful if I didn’t pass my driving test’: low frustration tolerance (LFT); the perceived inability to tolerate frustration or discomfort, e.g. ‘if I don’t pass my driving test, that will be intolerable’ and thirdly damnation
of self or other; globally and negatively rating ones self or other based on a particular action or trait, e.g. ‘I am a failure because I failed my driving test’. These beliefs are called irrational because they generate emotional disturbance or unhealthy negative emotions like anxiety and depression and are unrealistic, illogical and interfere with the pursuit of goals and purposes. (Dryden, 1995a; Dryden & Neenan, 1996; Dryden, 1991).

Beliefs that are flexible and based on wants, desires and preferences are called rational because they are realistic, logical and help the individual in the attainment of their goals and purposes and usually reduce emotional disturbance and lead to healthy negative emotions like concern and sadness. Flowing from these preferences are three major derivatives and helpful alternatives to the irrational beliefs: anti-awfulising; negative events are placed on a continuum of 0 - 99.9% badness where 100% bad does not exist as one can usually think of something worse, e.g. ‘it would be bad but not the end of the world if I didn’t pass my driving test’: high frustration tolerance; the ability to tolerate frustration or discomfort despite having one’s goals blocked, e.g. ‘if I don’t pass my driving test, that would be difficult but I can tolerate it’ and thirdly acceptance of self or other; humans as seen as fallible but worthy despite their traits or actions, e.g. ‘I don’t like the fact that I failed my driving test but I
accept myself as a fallible human being and my worth does not depend on whether I pass or fail my driving test’. (Dryden, 1995a; Dryden & Neenan, 1996; Dryden, 1991).

REBT theory posits that cognitions, emotions and behaviours are not independent of each other but interact and overlap, usually in complex ways and that these beliefs play the most significant role in creating emotional health and disturbance. (Dryden, 1991). This is conceptualised through its ABCDE model of emotional disturbance and emotional health.

In the model, taken from (Neenan & Dryden, 1999),
A= activating event (actual or inferred, past, present or future occurrences, internal or external)
B= evaluative beliefs which mediate the individual’s view of these events
C= emotional and behavioural consequences largely determined by the individual’s beliefs about these events
D= disputing disturbance producing ideas, particularly irrational beliefs
E= a new and effective rational outlook.

The new and effective rational outlook is maintained through rigorous work and behaviour in accordance with the new rationale.

REBT, as advocated by Ellis, should preferably be elegant and active-directive in style (Dryden, 1995a). Elegant REBT,
also known as preferential or specific is defined in Dryden & Neenan, (1996) as follows:

'preferential REBT: seeks to effect a profound philosophic change in an individual's attitude by uprooting her irrational beliefs and replacing them with rational beliefs. Features of specific REBT include understanding the role of flexible and rigid evaluation in largely creating, respectively, emotional health and disturbance; striving to accept oneself and others unconditionally as fallible human beings; seeking pervasive and long lasting change rather than symptom removal; disputing the philosophical core of emotional disturbance rather than inferences derived from the must; keenly discriminating between appropriate and inappropriate negative emotions (depression and sadness).

Ellis (1962) maintains that REBT is appropriate for any kind of psychological problem, such as anxiety disorders, sexual problems and depression, but not for severe disorders. He also maintains that REBT helps clients to cure themselves in an elegant way because it can be incorporated into their way of life.
Elegant versus inelegant therapeutic methods

From Ellis’ perspective, modern psychotherapy takes two major forms: inelegant or elegant methods. He sees the majority of today’s therapy to comprise of the former. Inelegant techniques, including very basic cognitive reframes, require individuals to make arbitrary but practical statements about themselves, such as “I accept myself as worthy, or I evaluate myself as worthy because I am alive.” This proposition, while empirically unverifiable, is likely to result in feelings of self confidence and even self-acceptance. It has many advantages and some disadvantages, and will usually preclude feelings of worthlessness and self-vilification as long as the proposition is held. Some of the more popular inelegant therapy techniques available today include:

Ego-strengthening. In ego-strengthening the therapist shows clients that they can be successful in their endeavours, if they keep working at it. Clients are never relieved of the posit that they must succeed at something in order to accept themselves and enjoy life. In other words, clients continue to be dependent on success in order to accept themselves as worthy.

Abreaction and Catharsis. The therapist invites clients to ventilate feelings, especially those related to anger and self-pity. Whereas some people temporarily feel better when using abreaction and catharsis, they rarely get better. That is, the
dysfunctional emotions only temporarily abate, while their disturbance-generating worldview remains.

**Diversion and Distraction.** Diversion involves the use of various diversionary techniques either outside or inside sessions, including meditation, yoga, relaxation, massage, sensory awareness exercises, intellectual dialogue, artistic pursuits, and a multitude of other diversions. According to REBT, diversions do not permanently address basic demands.

**Love Substitution.** The therapist relates warmly to depressed and “unloved” clients and gives them substitute love. Clients are confirmed in their irrational belief that they need love to feel worthwhile. They are not helped to change their basic demands.

**Operant Conditioning.** In operant conditioning the therapist uses reinforcements or aversive penalties to help clients achieve their goals. One typical example is helping a client learn to love the “right kind of” person or stop loving the “wrong kind of person.”

**Desensitisation.** The therapist might try to desensitise clients’ anxiety or guilt regarding rejection from self and others. Unless accompanied by cognitive reconstruction, clients must have to be desensitised many times as new and different situations arise.

**General REBT:** General REBT is inelegant because according to Dryden & Neenan, 1996 it 'helps clients to effect a change
at non philosophical level ... General REBT tackles clients inferences about their problems rather than their disturbance producing irrational philosophies; seeks symptom removal rather than profound philosophic change, teaches conditional self esteem rather than unconditional self acceptance, does not clearly discriminate between healthy and unhealthy negative emotions and uses gradual desensitisation methods rather than implosive ones’.

In contrast, elegant REBT uses methods that aim to philosophically change irrational beliefs to rational ones. This change is viewed as elegant and long lasting. They involve clients only rating or measuring their **behaviours, acts and performances**, not their worth as a person. Clients are taught not to rate themselves, their “essence,” or their “totality” in any way. From an elegant REBT perspective, people can accept that they have no intrinsic worth or worthlessness, but that they are alive, and that is what counts. They learn to rate their acts and traits but not their selves.

REBT recommends elegant solutions because they are more honest, more pragmatic, and result in fewer philosophical difficulties than inelegant solutions. And for clients who insist on self-rating, elegant REBT, then, suggests that they rate themselves as good merely because they are alive. Or as Ellis put it himself in a 1994 revised version of his article, “Showing People They Are Not Worthless Individuals” (1965):
“Perhaps the most common self-defeating belief of disturbed people is their conviction that they are worthless, inadequate individuals who essentially are undeserving of self-respect and happiness. This negative self-evaluation can be tackled in various ways – such as by giving them unconditional positive regard (Carl Rogers), directly approving them (Sandor Ferenczi), or otherwise giving them supportive therapy (Lewis Wolberg). I prefer, as I have indicated in my books Reason and Emotion in Psychotherapy and How to Stubbornly Refuse to Make Yourself Miserable About Anything – Yes, Anything!, an active-directive discussion of the clients’ basic philosophy of life and teaching them that they can view themselves as okay just because they exist, and whether or not they are competent or loved. This is a central teaching of rational emotive behaviour therapy” (Ellis, 1994).

Elegant REBT employs several useful techniques to persuade, educate, and train clients to give up their fundamental demands and instead aim for those goals they strongly want rather than what they believe they positively need.

Some of the methods employed in elegant solutions include:

**Cognitive assignments.** These are designed to help clients understand the REBT model and the functions that beliefs play
in causing and maintaining psychological health and disturbance. They also provide ways of identifying and changing irrational beliefs.

**Reading assignments.** These are designed to help clients gain understanding of REBT philosophies. According to Dryden (1995b), a large number of clients hold the belief that re-reading articles helps them to automatically absorb REBT principles into their actions and emotions.

**Listening assignments.** These are designed for clients whose primary modality is auditory as opposed to visual. Tapes from the Institute of Rational Emotive Therapy can be obtained. Also tapes of the therapy session can be listened to.

**Imagery assignments.** According to Dryden (1995b), imagery assignments help clients make use of their cognitive and affective modalities. Clear images, he points out, are 'affect laden when they embody inferences that are central in the client's personal domain'. Imagery assignments are also used to help identify irrational beliefs about future events to help prepare clients for behavioural tasks.

**Behavioural tasks.** The REBT therapist generally employs in **vivo** activity-oriented homework assignments. Clients are helped, for example, to stay with frustrating conditions to increase their tolerance to negative affect unpleasant conditions. Behavioural tasks are used with cognitive tasks to strengthen rational beliefs.
**Emotive/Evocative tasks.** These tasks fully engage the clients' emotions. They can be behavioural or imagery tasks. They are designed to be used with force and energy to help the client gain emotional insight.

In many ways, REBT practitioners use a combination of cognitive-emotive-behaviour methods to reveal to the clients their root antisocial and self-destructive philosophies, as well as what they can do to actively and exactly modify them. The goal becomes helping clients to accept reality, surrender their demandingness and compulsiveness, and maximize their freedom of choice to fulfill their human potential for growth and satisfaction (Ellis, 1962, 1988; Ellis & Grieger, 1986).

In short, significant and valid differences between theories of counselling are discernible, particularly in terms of inelegant and elegant approaches and outcomes in therapy. Ellis advocates the elegant approach rather than other counselling models (e.g., solution-focused counselling, psychoanalysis) insofar as it is designed to help people ameliorate both present and future disturbances. It follows that any distinctions drawn between elegant and inelegant methods correspond to fundamentally different ways of conceptualising the nature of problems and change. As historian of science Thomas S. Kuhn (1970) once suggested, “The proponents of competing paradigms practice their trades in different worlds”.
Hypnosis and Hypnotherapy

Hypnosis has traditionally been defined as an altered state of consciousness, a trance like state, where responsiveness to suggestions are heightened and the recall of hidden memories is facilitated (Hilgard, 1986). The rationale for its use is that in the hypnotised state the conscious mind presents fewer barriers to effective psychotherapeutic exploration, leading to an increased likelihood of psychological insight (Heap, 1988). Other opinions have considered the so-called “hypnotic trance” to be a very relaxed mental state attained via guided imagery and meditation (McMaster, 1992, 1996). Discrepancies in the defining points of hypnosis have arisen due to the large individual differences in “hypnotisability” (Crawford, Brown, & Moon, 1993) and the large number of competing theoretical models (Kirsch & Lynn, 1998; Kihlstrom, 1998). Further, theoretical explanations for hypnotic phenomenon have been found to be derived from dissociation theories (Hilgard & Hilgard, 1994).

Traditional definitions, though containing an element of truth, are very limited in their usefulness. Most tend to describe hypnosis from the client's position in the trance state without accounting for the role of the hypnotherapist. All imply a passive response to suggestions due to the state termed 'trance' (Yapko, 1989).
Commonly people consider hypnotherapy to only rely on the use of suggestions and suggestibility to induce change in people’s lives. This is one of the many theoretical perspectives that attempt to explain hypnosis and its therapeutic use i.e. hypnotherapy. Many clinicians conceptualise hypnotherapy as persons wanting to be hypnotised, visiting a hypnotherapist and undergoing the process of hypnotic induction, in which typically they fixate on a target object (e.g., metronome, whirling disk, pendulum; Hartland, 1971). Specific induction wording directs clients’ attention inward to reduce vigilance of the external world. The induction’s wording is usually associated with passive mental states (e.g., relaxation, medication, and sleep), and focuses subject’s awareness on concrete images, sensations, and behaviour, while also diminishing logical, critical, and abstract cognitive processes (Barnett, 1992; Lynn, Rhue, & Weekes, 1990).

In contrast, hypnosis has also been described as a state of increased awareness (Kroger, 1977; Yapko, 1989). So if a person becomes more aware, the message sinks in better and if the message sinks in better the response is better. The implication being the message communicated is transmitted and received more clearly.

Yapko (1989), defines hypnosis as a 'process of influential communication', where the hypnotherapist uses vivid
and emotive words and gestures in a skillful manner to increase the potential for influencing healthy psychological change. Hypnosis is therefore seen as a **persuasive communication tool**. Less emphasis is placed on ritualistic methods or on the attainment of different depths of trance.

There are numerous theoretical perspectives about the hypnotic phenomena and hypnotherapy (Kroger, 1977; Hartland, 1971; Barber, 1996; Yapko, 1989). Hypnosis and hypnotherapy will be used according to how they are conceptualised. These different theoretical perspectives have both helped and hindered the application of hypnosis. Theories are useful for a number of reasons but most importantly because they guide therapists in their work and in their choice of procedures (Dryden, 1991). However, this is also a limitation when applied to hypnotherapy because some of the theoretical perspectives of hypnosis are more limited than others and currently no one single theory adequately explains its complexity.

Skilled hypnotherapists generally work in an integrative and sometimes eclectic way drawing upon the broad spectrum of psychotherapeutic philosophies and treatments. Hypnotherapy is therefore a form of psychotherapy where counselling skills are used, a full case history is taken, rapport or therapeutic alliance established, problems and goals defined, misconceptions dealt with and therapeutic strategies, for both
the hypnosis and non hypnosis part of the session, discussed and agreed. Hammond (1990), points out therapists that rely on a limited range of methods and one approach only often tend to be inexperienced. He cites Lieberman, Talom, & Miles (1973) who suggest that problems are more likely to occur when the same approach is used with all clients. Therefore how hypnosis, the mind and hypnotherapy are conceptualised determines the limits placed on their use and on clients (Yapko, 1989).

Some of the goals of the hypnotic part of the session might include relaxing (Marriott, 1996), challenging irrational beliefs (Davis, 1994, 1995; McMaster, 1996), recovering repressed memories (Loftus & Ketcham, 1994), relieving pain (Weiss, 1993), relieving tinnitus (Burte, 1993), treating post-traumatic stress disorder (PTSD) (DelMonte, 1993, 1995) and Tourette’s syndrome (Crawford, 1992), eliminating panic attacks and phobias (Davis, 1994, 1995), and treating multiple personality disorder (Spanos & Burgess, 1994). In fact, these and many other conditions have been shown in the professional literature to respond well to clinical hypnotherapy (Palmer & Dryden, 1995; Rhue, Lynn, & Kirsch, 1993). The treatment of the majority of the conditions stated would involve more than one approach.
Hypnosis and REBT: An “elegant combination?”

REBT practitioners will probably have clients requesting hypnosis. Hypnotherapists trained in REBT will probably be interested in working elegantly, as elegant REBT is both preferred and advocated by Ellis. Ellis (1986, 1993) has highlighted a number of similarities between hypnosis and elegant REBT. Both traditional hypnosis and REBT are:

“…highly active-directive, they emphasise homework assignments and in vivo desensitisation and urge clients to actively work against their low frustration tolerance (LFT) and self-defeating behaviours. Because of this degree of overlap between some of the basic theories and practices of REBT and hypnotherapy, Ellis sometimes combines REBT with hypnosis” (Ellis et al., 1997).

However, Ellis views hypnosis as an 'inelegant solution to the problem of disturbance', (Ellis, 1996). In order to understand why he holds this view it is important to ascertain how he conceptualises hypnosis, which in turn guides his application of it. Ellis' view appears to be advocated by other REBT practitioners such as Palmer and Dryden (Palmer, 1993, Palmer and Dryden, 1995). Ellis appears to agree with Barber (1961), Bernheim (1900) and Coue' (1921), in holding the view that hypnosis works through suggestion and mainly consists of giving clients strong positive statements and inducing them
to internalise and act on these statements, (Ellis, 1993). The theory advocated is the theory of Suggestion proposed by Bernheim.

The theory of Suggestion (Hartland, 1971) states that hypnosis is a state of mind induced by one person to another. In this enhanced suggestibility state, different from the waking state, suggestions given are uncritically accepted and acted on by the recipient. Suggestion is defined as 'a process whereby an individual accepts a proposition put to him by another, without necessarily having a logical reason for doing so. Suggestibility is defined as 'the degree to which an individual is inclined towards uncritical acceptance of ideas and propositions'.

Ellis often only uses hypnosis for a single session - and then cautiously. Wherever possible he prefers not to use hypnosis alone, but will use it with REBT. Ellis once remarked in an interview:

"When people ask me for hypnosis I often talk them out of it. Why? Because they have usually read somewhere that it does magic and it will help them enormously with very little work on their part. I therefore try to help them see that this isn’t so and try to get them to use REBT without hypnosis" (Dryden & Ellis, 1995).

Ellis acknowledges that hypnosis as a therapeutic adjunct to REBT has been found to be beneficial for many individuals,
although suffering from some shortcomings (Ellis 1993; Ellis 1996). Depending upon how it is used, its disadvantages according to Ellis include:

1. It does not necessarily help clients think for themselves. They without critical thought adopt the hypnotist's suggestions. Suggestion is low level thinking and not high level falsification practised by good therapists.

2. It encourages magical thinking.

3. It can reinforce LFT.

4. It can reduce clients’ hard work and practice.

5. It does not help clients to consciously look for self defeating beliefs nor challenge them cognitively and behaviourally.

Ellis points out the primary aim of REBT is to help clients consciously see and understand their irrational beliefs, that they disturb themselves because they hold and maintain their irrational beliefs and that by steady work and practice they can give up their demand and replace them with preferences.

However, from a pragmatic position, he accepts some clients find hypnosis advantageous, and in certain circumstances the technique of giving strong direct positive suggestions may be worthwhile. Ellis and associates concluded that:
“...when combined with REBT it [hypnosis] can significantly help clients who resist using REBT’s cognitive, emotive and behavioural methods to become less distressed about the stressors in their lives” (Ellis, 1997).

It is easy to appreciate Ellis’ view given his conceptualisation of hypnosis and acceptance of the theory of Suggestion. However, the theory of Suggestion is limited for a number of reasons. First, if all hypnosis was suggestion as Bernheim proposed, and he spoke of suggestions and not suggestibility, then it does not account for many of the hypnotic phenomena that occur naturally in the waking state. Second, the theory suggests that in deep hypnosis the conscious mind and its power are bypassed and suggestions can not be rejected. There is no evidence to support this. Third, the client is viewed as passive and permissive without a will of his or her own and finally Yapko (1989) makes the point that a hypnotherapist can be either permissive or authoritarian in offering suggestions. So if a hypnotherapist adopts a permissive style, the theory of Suggestion is no longer plausible because the client is required to be more active.

The theory of Suggestion does contain some truth but overall it is now widely accepted as flawed. It assumes the client is a passive receptor of suggestions and the hypnotherapist is active and commanding and whose suggestions can not be rejected. In truth, the client allows the actions
of the hypnotherapist and therefore the role of the client is not passive. It is the client's responsibility to respond fully or partially to the suggestions of the hypnotherapist.

Reflecting back on the points made by Ellis about the disadvantages of using hypnosis (see page 22), it can now be argued that:

1. Clients may not necessarily be helped to think for themselves if all that happens in the session is authoritarian direct suggestions and if the theory of Suggestion is completely advocated. Hypnosis involves a person’s ability to set aside critical judgment without relinquishing it completely, as well as to engage in make-believe and fantasy (Gill & Brenman, 1959; Hilgard, 1971). For some people this make-believe may be so vivid and intense that they have trouble differentiating it from reality. But in the majority of cases, cognitively intact persons are able to maintain at least some level of rationality regardless of the nature of the hypnotic suggestion (Rhue, Lynn, & Kirsch, 1993).

Hypnosis is not mind control or brainwashing. People change their minds and actions everyday of their lives. When such changes occur as a result of exposure to specific information, it is because this information has been presented through persuasion and influence (Petty & Cacioppo, 1986; Rhue, Lynn, & Kirsch, 1993). It is true
qualified hypnotherapists use communicative methods of persuasion and influence, but so do advertisers, producers of goods and services, parents, teachers, politicians, entertainers, lawyers, ministers and REBT therapists. Hypnosis cannot cause clients to act against their will or contradict their values. A hypnotherapist is ethically required to make only those suggestions that support agreed upon outcomes. Agreed upon outcomes are discussed and disputed at the outset. Clients are never receptive to suggestions that go against their morals or values, as client receptivity is one of the main ingredients of success in hypnosis. Adapting oneself to suggestions in a meaningful way is not a passive state.

2. It is not hypnosis that encourages magical thinking but how it is used and perceived. Clients have misconceptions about many philosophies and therapies. It is the responsibility of the therapist to deal with these misconceptions professionally and appropriately. Dryden, 1995 deals with the fifteen most common REBT misconceptions. Yapko, 1989, deals with the eleven most common misconceptions of hypnosis. Many of the complications that can occur during hypnosis (e.g., inability to enter a trance) stem from the hypnotised person’s perceptions of the hypnotic process (MacHovec, 1986). Most problems are avoidable by carefully
questioning the person concerning his or her understanding of hypnosis prior to the session. Beliefs that any hypnotised person is unable to resist any suggestion that is applied, or will not be able to terminate the trance state, are best met with simple facts. Research indicates that while hypnotised persons are susceptible to suggestion, there are limits. Persons with normal cognitive processes seem to be able to maintain at least some level of rationale and logic under hypnosis (Rhue, Lynn, & Kirsch, 1993).

3. Hypnosis and hypnotherapy rely on the active participation of the client both in trance and in carrying out the agreed homework tasks. Homework tasks can be cognitive, behavioural or both. In fact, Ellis points out that both traditional hypnosis and REBT emphasise homework assignments.

4. Hard work and practice may be reduced but so will successful treatment if all that is agreed with the client is listening to a tape of general suggestions made by the therapist. Limiting hypnotherapy in this way will very likely make for poor therapy. It should be remembered that self motivation, commitment and preparation are key ingredients of self hypnosis.

5. It is the hypnotherapist who only uses direct suggestions that is putting a limit on both the
hypnotherapy and the client. Ellis also suggests that hypnosis does not help clients to consciously look for their beliefs. But Sarbin & Coe (1972) point out hypnotic trance is not a separate and unique aspect of consciousness. For example, trance happens when someone engages in role play or when someone focuses to recall events (Gullo, 2001). Gullo goes further to suggest the active process of disputation involving concentration, focus and retrieval of subconscious information is hypnotic albeit light. Therefore, clients do not enter into another realm of consciousness that is very different from any other. Recently trance has been defined as state of concentrated attention and since trance phenomena are found in daily activities it can no longer be unique and separate. It is a natural and a routine state of every person's mental processing (Yapko, 1989). This recent definition provides another possibility for identifying irrational beliefs.

It is true that enhanced suggestibility is a feature of the active process of hypnosis. Suggestions are made to clients. However, suggestions are also made in disputing and Ellis points out that disputing includes scientific debating, persuasion, suggestion and positive thinking (Ellis, 1993), all of which take place in a hypnotherapy session and in hypnosis. The objective for both is to persuade clients to let go of
their irrational beliefs and adopt the rational alternatives. If enhanced suggestibility is inelegant, as Ellis may be implying, then it is worth exploring the notions of suggestibility, suggestions and persuasion further and the factors that influence them.
Suggestibility, suggestion and persuasion

At the heart of hypnosis is the phenomenon of hypnotic suggestibility, which is a state of greatly enhanced receptiveness and responsiveness to suggestions and stimuli presented by the hypnotist, provided they are acceptable to the individual (Kroger, 1977). Suggestion in psychology refers to the process of leading a person to respond uncritically, as in belief or action. The mode of suggestion, while usually verbal, may be visual or may involve any other sense. It should be kept in mind that hypnotisability (i.e., the ability to enter into a hypnotic trance) is distinct from suggestibility (i.e., proneness to accept suggestions once in a hypnotic trance). This difference has been confirmed independently by Gudjonsson (1987) using a suggestibility scale that he developed. Suggestibility is enhanced by favourable attitude and mental state. It does not depend on the technique used but on the quality of the relationship between the client and the hypnotherapist. In hypnotherapy, rapport is considered one of the factors that influence hypnosis (Kroger, 1977). Rapport is synonymous with the components of therapeutic alliance, namely goals and tasks but in particular with bonds. Developing a working alliance with clients from the beginning is important in REBT (Dryden, 1995c). In fact Dryden suggests varying the therapeutic bond because different clients respond to different bonds. Therefore, when REBT practitioners make suggestions to
their clients, an established strong bond enhances client suggestibility. Good rapport and bonds influence suggestibility whether in hypnosis or not. This enhanced suggestibility state will have a bearing on persuasion, discussed later on.

There have been a few recent attempts to find physiological correlates of hypnotic suggestibility. One of these was the EEG research of Spiegel and associates (Spiegel & Cardena, 1991; Spiegel, Cutcomb, Ren, & Pribram, 1985), who seemed to find an evoked response pattern that appeared during hypnotically suggested hallucination, yet not during simulation of hypnotic hallucination. Spanos (1986) and others have argued that this EEG data has been misinterpreted given the nature of the control subjects used. It is possible that further study during hypnosis may establish some correlation between contextual factors, social influences, the physiological state of the brain, and underlying cognitive mental processes (Spanos, Gabora, Jarrett, & Gwynn, 1989; Spanos, McNeil, & Stam, 1982).

Studies of clinical populations have shown that individuals afflicted by trauma-related or dissociative disorders are readily hypnotised (Frankel, 1994), and hypnosis appears to be an effective clinical tool for these patients (Jiranek, 1993; Leung, 1994). Many authors believe that similar psychological processes underly hypnosis and dissociative or
trauma-related disorders (Hilgard, 1986). Specifically, early trauma is believed to induce a “hypnotic state” in predisposed individuals as a defense from traumatic events such as physical and sexual abuse. This is thought to create a vulnerability for repeated dissociative behaviours and the development of alter personalities (Frankel, 1994). The similarity in the theoretical basis behind dissociative disorders and hypnosis is considered as a reason for its effectiveness (Spanos & Burgess, 1994). This is useful for REBT because its treatment strategies can be differentiated according to the presenting problem.

Employing hypnosis for trauma-related problems has been around from the time of Freud (Spiegel, 1986). Brom, Kleber, & Defres’ (1989) controlled study of 112 trauma victims treated by hypnosis compared desensitisation and psychodynamic therapy versus a waiting list control group. According to pre-treatment interviews, all subjects met the symptom criteria for post-traumatic stress disorder (PTSD). Improvements over the waiting list condition were discovered under all three conditions. However, Brom et al.’s (1989) study could have succumbed to an expectancy bias in all active treatment conditions, primarily because their outcome measures were based on post-treatment self-report measures.

A hypnotic suggestion can be symbolic, and if accepted can induce a remarkably wide range of psychological, sensory, and
motor responses from persons who are profoundly hypnotised. By acceptance of and response to suggestions, subjects can become deaf, blind, paralyzed, delusional, amnesiac, or resistant to pain or discomfort from contorted body postures. Or they can display behavioural responses that they consider to be reasonable within the hypnosis setting, even though the hypnotist suggested it.

The results of hypnotic suggestion are numerous. Many subjects seem unable to recall what happened while they were in deep hypnosis. This posthypnotic amnesia, as it is termed, can either result spontaneously from deep hypnosis, or it can result from suggestion by the hypnotist during the trance state. The amnesia may include all the events of the trance state or only selected items, or it may be manifested in connection with matters unrelated to the trance. Posthypnotic amnesia can be successfully removed by appropriate hypnotic suggestions (Zilbergeld, Edelstein, & Araoz, 1986).

Another fascinating manifestation that can be elicited from a subject who has been in an hypnotic trance is that of post-hypnotic suggestion and behaviour. By this is meant the subject’s execution, at some later time, of instructions and suggestions that were given to him while he was in a trance. With adequate amnesia induced during the trance state, the person will not be aware of the source of his or her impulse to perform the instructed act. Posthypnotic suggestion, however,
is not a particularly powerful means for controlling behaviour when compared to a person’s conscious willingness to perform actions (Zilbergeld, Edelstein, & Araoz, 1986). Because of this many homework assignments agreed in hypnotherapy tend to be conscious and behavioural.

Finally, **hypermnesia**, which involves memory capacity transcending everyday ability, is another manifestation of hypnotic behaviour. For instance, in the trance state, the subject, by virtue of an uncritical willingness to make the effort and a freedom from inhibitions deriving from pre-formed judgments, can vividly remember long-forgotten, even deeply repressed experiences, recount them in extensive detail and still maintain an amnesia for them at the ordinary level of consciousness. This remarkable ability permits the recovery of memories that are otherwise unavailable to conscious awareness, and it was thus of great usefulness to Freud as he embarked on his explorations of his patients’ unconsciously held memories (Zilbergeld, Edelstein, & Araoz, 1986). Clearly this phenomena has an important application for REBT, namely identifying the critical A.

It is interesting to consider how a client is persuaded to accept suggestions. Research on what makes suggestions effective during hypnosis has yielded variegated results. Besides such factors as “hypnotisability” and “suggestibility”, tone of voice, appropriate setting, quiet surroundings etc.,
client receptivity and the import of the suggestion appear to be primary factors (Rhue, Lynn, & Kirsch, 1993). This is why many hypnotherapists prefer clients to ask for hypnosis. It is also why many practitioners use stories, metaphors, and other lively methods. Emotive and vivid stories appear to make the points being conveyed during both hypnosis, REBT, and cognitive-behavioural therapies more salient (Ellis, 1986, 1988, 1993).

Hypnosis has many clinical applications, and has thus been endorsed as a therapeutic method by psychological, psychiatric, medical, and dental associations around the globe. In the mental health arena, hypnosis has been widely used. For instance, the technique of revivifying traumatic events in order to produce an emotional abreaction continues to be a useful treatment in relieving anxiety with traumatic onset (e.g., following combat, rape, natural disaster) among persons with relatively stable prior adjustments. In the medical arena, hypnosis has been found most useful in preparing patients for anesthesia, enhancing drug responses, reducing required drug dosages, alleviating a pregnant mother’s discomfort during childbirth, and managing otherwise intractable pain (e.g., from terminal cancer). It is also valuable in reducing the widespread fear of dental procedures; dental patients frequently respond well to hypnotic suggestion. In the area of
psychosomatic medicine, hypnosis has been used to treat high blood pressure, headaches, and many other functional disorders.

Given all of these benefits, hypnosis when used with REBT is likely to be an exceptionally powerful tool for clinicians treating for people with psychological and physiological conditions.
Logical persuasion in hypnosis and cognitive response theory

From the point of view of cognitive-behavioural theory, the goal of psychotherapy, including both REBT and hypnotherapy, is to effect healthy, agreed upon change in the client (Zilbergeld, Edelstein, & Araoz, 1986). Central to this process is “persuasion” or logical persuasion when cognitive elements are involved (i.e., in contrast to subliminal persuasion based on stimuli presented below the usual threshold of perception). In other words, a therapist’s active attempts to help clients make changes in their beliefs, thoughts, feelings and behaviours involves, at a rudimentary level, logical persuasion.

As shown in the previous section of this paper, hypnosis is a prime example of the use of persuasion. In order for a suggestion to be accepted the client would have to be receptive to it. In the same way that REBT practitioners use stories, metaphors and scientific disputation so do skilled hypnotherapists. But can logical persuasion take place in hypnosis without discussing and debating the subject matter? To answer this question it may be useful to consider Ericksonian Hypnosis (named after the late psychiatrist Milton H. Erickson, M.D.) one of the most frequently practiced forms of hypnotherapy today. From the 1930’s to the 1980’s Dr. Erickson was very influential in bringing the use of clinical
hypnosis into the fields of psychotherapy and medicine. He taught and practiced a unique brand of hypnosis that was gently persuasive, indirect, permissive, and respectful of the client, but also included stories, metaphors, and life examples. Erickson also published the first professional journals and monographs on the therapeutic uses of hypnosis, and established the National Association for Clinical Hypnosis. The Ericksonian Foundation continues the work of Dr. Erickson, who has long been recognized as the most influential hypnotherapist in the world.

Some of the distinctive features of therapy and interventions associated with Erickson’s work are noteworthy, not for their uniqueness, but for their function as a vehicle to connect therapist and client as a team in the process of developing a context for change. Erickson is best known for his techniques of indirect persuasion, following his rejection of the traditional epistemology that favours the use of direct suggestions by experts who tell their clients precisely what needs to be done to overcome the problems they bring to the clinician (i.e., an “authoritarian” approach). Indirect suggestion, according to Erickson, is presented in such a way that clients will apprehend that portion that is of subjective value, and then apply it to the process of retrieving and associating experiences needed to achieve present goals. Indirect suggestion, however, is not passive. It makes use of
logical persuasion, albeit circuitous, and assumes actively participating clients with a certain degree of innate wisdom. This fits in with Ellis' view that humans are also constructivists (Ellis & MacLaren, 1998). Therapists learn from the response of their clients when to elaborate upon the presented ambiguity and innuendo in even more beneficial ways. So this means that in hypnosis indirect suggestions i.e. using stories, metaphors and life examples are made and the client's response gauged to ascertain that the healthy message was apprehended.

Hypnotherapy is only one means of inducing change in people via logical persuasion. Another field of inquiry that has proven to be an important approach to the subject of emotional and behavioural change is cognitive response theory. According to Cacioppo et al.'s (1981) definition, a cognitive response is defined as a unit of information pertaining to an object or issue that is the result of cognitive processing. In other words, it is a thought or attitude generated in response to logically persuasive communication. According to these same authors, an attitude is a broad and lasting impression - favourable or unfavourable - about an object or issue (Cacioppo et al., 1981; Petty, 1982).

By the mid 1950s, psychologists began showing an interest in the persuasive and emotional aspects of differing forms of communication between “senders” and “receivers” (Bagozzi,
Over the years, psychologists have attempted to ascertain whether a general factor of personality involving proneness to persuasion is identifiable and measurable within the general population. Research does suggest, within certain limits, that people can be persuaded to change their attitudes and social behaviours. Thus, rationally persuasive communication affects attitudes and emotions, which affect behaviours, which affect personal change (Nabi, 1999).

The cognitive response model is an attempt to discover how people attain and modify their attitudes toward an object or activity within the context of a persuasive situation (Petty & Cacioppo, 1986). The theory proposes that persuasion produced by an act of communication is, in reality, self-persuasion that is generated by the receiver while reading, listening to, or watching a communication of some type (though usually involving the media). These cognitions might revolve around a communication’s content or other aspects of an interaction, such as speculating on the source’s credibility or personal relevance. If a communication prompts feelings supportive of a position being advocated, the “receiver” will move towards that position. This is precisely the point when personal change is effected. Similarly, Coué (1923) said that clients use the hypnotherapist's suggestions and turn them into their own suggestions thus enhancing the original suggestions. This means that clients move towards the position suggested by the
hypnotherapist provided it is deemed appropriate or beneficial to them.

Unlike other theories of persuaded change, the cognitive response model stresses the importance of recipients’ own generated thoughts (“personal relevance”) instead of their retention of the content of interpersonal communication (Eagly & Chaiken, 1993). As such, the cognitive response model has many potential applications related to logical persuasion. For instance, it is useful for understanding clients’ attitude formation and change toward persuasive clinician’s messages, particularly in terms of the factors that inhibit or induce cognitive responses and eventually behaviours.

Information concerning the cognitive responses of a communication recipient, permits investigators to predict attitudinal change when individuals are exposed to persuasive communication both in and out of counselling (Eagley & Chaiken, 1993). For example, when individuals anticipate or receive a persuasive message, they actively relate the information in the message to their pre-existing thoughts about the topic, issue, or object. The thoughts generated by a receiver based on his pre-existing thoughts may be favourable, unfavourable or irrelevant (neutral) to the topic in the message. In cognitive response theory, individuals will tend to concur with suggestions that evoke favourable recipient-generated thoughts, while they will tend to disagree with suggestions that evoke
unfavourable recipient-generated thoughts. So, if cognitions that occur during clinical conversations are favourable, persuasion will take place. If cognitions are unfavourable, resistance will occur. This is relevant to the practice of REBT and perhaps makes sense of why pragmatic disputation appears to be apprehended and received more easily. In hypnotherapy, suggestions made in hypnosis or outside of hypnosis, guided scenarios and analytical techniques are usually structured in the most effective way for enabling their acceptance and absorption (Yapko, 1989; Kroger, 1977; Hartland, 1971). Such a message can of course be elegantly or inelegantly structured but it can remain true to REBT philosophies of emotional health. So hypnosis is a communications tool used to persuade clients to adopt an agreed upon outcome. It is an enhanced suggestibility state but enhanced suggestibility occurs outside of an induced hypnotic state too. Enhanced suggestibility and persuasion occurs in a favourable mental state influenced by the relationship between the therapist and the client and by favourable thoughts generated by the client following a message.

Cognitive responses, attitudinal change, and behavioural change are highly related and influence each other (Miller & Colman, 1981). Numerous research studies have found that the favourable thoughts are positively correlated with attitude change, and that unfavourable cognitions are negatively
correlated with persuasion (Petty & Cacioppo, 1986). In other words, cognitive responses mediate attitudinal change, including the formation of a final attitude and decision to alter emotional state and behaviour.

Cognitive responses are related, at least in part, to behavioural change (Cacioppo et al., 1981; Petty & Cacioppo, 1986). Persuasion, then, is not necessarily a direct result of cognitive responses only, but occurs in response to a variety of physical, psychological, and sociological mitigating factors. Hence, a positive relationship between persuasion, attitude and change exists, but mostly when taking other factors into account.

Persuasion as a key feature of REBT and hypnotherapy has undoubted long-term efficacy in counselling (Ellis, 1986, 1993; Ellis & Bernard, 1985). All of the areas in which these modalities have been shown in the literature to be effective—anxiety, stress, headaches, trauma, etc. (as listed in an earlier section of this paper) present convincing evidence of the very broad applicability of these persuasion-based therapies.

Long-term clinical “effectiveness” brings up the issue of “cure,” the view of which reflects ideological differences in therapists’ respective approach. The traditional view (e.g., Freudian and psychodynamic theories) of cure is based upon a past-orientation. It is related to resolving internal
conflicts, building the client’s ego strength, lessening resistance to change, eliminating symptoms, and promoting the client’s capacity to love and work. The emphasis in such a scenario is on the client who “works through” events from the past about which she or he was conflicted, lacked cognitive strength, or developed irrational beliefs and cognitive distortions. This often involves a gradual gaining of insight within therapy, including corrective emotional expression. From a present-oriented perspective (e.g., REBT, hypnotherapy) though, long-term “cure” has another meaning. The focus from this perspective is on healing today; the familiar “here and now” focus. Consequently, cure is determined on the basis of the relinquishing of irrational beliefs, unhealthy attitudes and symptoms, as well as developing functional behaviours and adaptive relationships within the present social environment. Cure also denotes the acquisition of new skills for handling future demands.

That said, and as noted above, a key figure in the practice of logical persuasion in psychotherapy was Milton Erickson. The long-term efficacy of this psychotherapeutic method of logical persuasion has also been well-documented (Erickson, Rossi, & Rossi, 1976; Weiss, 1993; Zeig, 1985).

In contrast are methods like psychoanalysis that rely on past-oriented interpretation of internal conflicts rather than logical persuasion. Most scientific-empirical research has not
reported the long-term efficacy of Freudian and neo-Freudian insight therapies; in fact, the opposite is often the case (Torrey, 1992).

Hypnotherapy can be Hypno-REBT, Hypno-analysis, Hypno-behavioural or Hypno-CBT. Hypno-REBT does not mean using the state of hypnosis to offer authoritarian direct suggestions only. Apart from Ellis' direct suggestions approach which is inelegant (largely because specific beliefs are not identified, disputed and their healthy alternatives not constructed, disputed and integrated) another approach does exist in Rational Stage Directed Hypnotherapy.
Rational Stage Directed Hypnotherapy

One form of therapy that combines hypnosis and cognitive work is Rational Stage Directed Hypnotherapy (RSDH), also known as Cognitive Experiential Therapy (CET). RSDH or CET is a hypnotherapeutic procedure that is an extension and modification of Ellis' REBT, and combines hypnosis, imagery and the cognitive restructuring of self-defeating cognitive, emotional, physiological, and behavioural tendencies (Gwynne, Tosi, & Howard, 1978; Howard, Reardon, & Tosi, 1982). It includes four key components: (1) the hypnotic state; (2) the identification, vivid imagining, and experiencing of self defeating as well as self enhancing thoughts, emotions, physiological responses and behaviours; (3) the cognitive restructuring of irrational attitudes i.e. disputing, challenging, confronting cognitive distortions and irrational ideas and ultimately replacing them with more rational ones and (4) the directing of these processes through six developmental stages of awareness, exploration, commitment, implementation, internalisation and change or redirection' (Boutin & Tosi, 1983). Two standardised instruments often used in RSDH assessment are the Common Beliefs Survey III (CBS EII) and the Millon Behavioural Health Inventory (MBHI).

RSDH or CET has been shown to be an effective means of modifying unwanted behaviour (Murphy, Tosi, & Pariser, 1989). For example, Boutin and Tosi (1983) investigated the effects of
four treatment conditions on the modification of test anxiety and irrational beliefs in female nursing students: a group receiving RSDH (i.e., cognitive behavioural hypnosis and vivid-emotive-imagery), a group receiving hypnosis-only treatment, a placebo group, and a no-treatment control group. The 48 subjects were assigned randomly to one of these treatment groups, which met for 1 hour per week for 6 consecutive weeks and were assigned in-vivo homework assignments. Statistically significant treatment effects for affective, cognitive, behavioural, and biological measures were observed in both the RSDH and hypnosis group following initial testing and follow-up testing, two months later. Post-hoc analysis showed significant improvement in the RSDH treatment group versus the hypnosis-only group at both post-testing and follow-up. Neither the placebo or control groups demonstrated any significant effects at post-testing or follow-up.

In another study, Tosi, Judah, and Murphy (1989) evaluated the effects of a CET on duodenal ulcer syndrome. Seven criterion variables were assessed using two standardised instruments and questionnaire data. The standardised instruments included in this study were the Millon Behavioural Health Inventory (MBHI) and the Common Beliefs Survey III (CBS Ell). The authors found CET had a positive effect in reducing duodenal ulcer syndrome in the sample studied.
The literature on detailed RSDH is sparse, but has shown promise (Boutin & Tosi, 1983; Tosi & Murphy, 1994). It is unclear however whether the procedure, which could prove to be both an effective and “elegant” intervention combining both hypnosis and cognitive restructuring techniques for a large variety of conditions, specifically identifies irrational beliefs. Further the ABCDE model in RSDH is different from Ellis' ABCDE paradigm. In RSDH:

- **A** = Situation
- **B** = Cognition (thoughts, attitudes, appraisals)
- **C** = Emotional response (affect; anxiety, anger etc.)
- **D** = Physiological Concomitant (headaches, increased heart rate etc.)
- **E** = Behavioural response (approach/avoidance tendencies).

Specific examples of cognitive responses were not reported in the literature. For this reason it should not be assumed that it is an elegant form of REBT but it may be.

Like other forms of hypnotherapy, RSDH makes significant use of imagery. REBT practitioners make use of both vivid and emotive methods in therapy as discussed earlier.
The impact of imagery on cognition and belief systems

Imagery, sometimes known as guided imagery or visualisation, is both a mental process (as in imagining) and a multitude of procedures used in therapy to promote changes in attitudes, behaviour, or physiological reactions. As a mental process, it is often defined as “any thought representing a sensory quality” (Horowitz, 1983). It includes, as well as the visual, all the other senses - tactile, aural, olfactory and kinesthetic. As a compilation of techniques, imagery is based on Ahsen’s (1968) theory that personality and consciousness are made up of images, and to correct personality one must identify and change distorted images. The client explores the internal forms that help to increase his understanding of her or his behaviour. Thereby, she or he gains more control over the behaviour (Achterberg & Lawlis, 1982).

In a nutshell, guided imagery as a clinical tool involves deliberate focus of attention on specific images to bring about wanted changes in experience or behaviour. It has more in common with cognitive psychological approaches than strictly behavioural ones, although there is overlap. Meichenbaum (1978), for example, has contended that use of imagery is an effective therapeutic method that operates through the feeling of control resulting from rehearsal of new behavioural responses and coping skills, and the consequent modifications
of the internal dialogues or narratives through which meaning is attributed to situations.

Whether imagery differs from hypnosis in terms of purpose and state of consciousness has been the topic of much debate. Hypnotherapists, especially those who train clients in self-hypnosis, are often indistinguishable from practitioners of imagery. What has been agreed on is that there is a correlation between the ability to image and the capacity to enter into an altered state of consciousness, including the hypnotic state (Barber, Spanos & Chaves, 1974; Hilgard, 1974; Lynn & Rhue, 1987).

While guided imagery is similar to hypnosis in its emphasis on reduction of reality testing, redistribution of attention, and emphasis on fantasy, it also differs from hypnosis in a number of ways (Lynn & Rhue, 1987). The objective in guided imagery is not necessarily characterised by a lessening of desire to make and carry out plans according to one’s own will, nor does it involve suggestibility to the hypnotist’s suggestions. Its objective is also not to relieve pain, nor to gain access to unconscious material, or to accelerate learning, as is common in hypnosis. Nor does imagery involve hallucination, dissociation, delusion, or post-hypnotic amnesia; it is vividly remembered. However, Kroger (1977) states that hypnosis 'greatly facilitates the production of imagery'. Whilst others (Glick, 1970; Deiker and Pollock,
1975) indicate that visualisation is enhanced during the hypnotic state. Boutin and Tosi (1983) cite Maultsby (1971) and Tosi (1974) as suggesting the overall emotional effect of real or imagined stimuli are qualitatively the same. This clearly has applications in Hypno-REBT. Imagery is a common ingredient in many behavioural therapies not specifically labeled as guided imagery or visualisation. When combined with self hypnosis imagery can be taught either individually or in groups, and the therapist often employs it to bring about a distinctive result (e.g., enhancing immune functioning during cancer, cessation of smoking).

Practices that have a component of imagery are practically universal. These include biofeedback, neurolinguistic programming (NLP), desensitisation and counter-conditioning, REBT, gestalt therapy, hypnosis, and many others. In fact, any therapy that makes use of imagination, visualisation, or fantasy to communicate, motivate, solve problems, or elicit intensified sensitivity or awareness could be labeled a form of imagery. Types of meditation that entail reciting a mantra could also be developed as forms of imagery. Likewise, relaxation techniques and autogenic training that involve instruction (e.g., “Your hands are heavy”) have a component of imagery (Crawford, 1982, 1992).

The process of imagery divides into at least three major classifications: (1) evaluation or diagnostic imagery, (2)
mental rehearsal and (3) therapeutic intervention. Techniques used in evaluation or diagnostic imagery involve asking the person to describe his or her condition from a sensory point of view. The therapist gathers data concerning the problem, disease, the result of treatment, and any innate, inner healing resources the person might be sensing. The patient is literally asked, "How do you feel?" In psychotherapy settings, dreams or fantasies might be used in this way, as a means to gaining control or insight over a situation (Ellis, 1993; Rhue, Lynn, & Kirsch, 1993). In Hypno-REBT this could be used to identify the unhealthy negative emotion and the critical A. Wells and Hackman, (1993), explored whether images that occur spontaneously during health anxiety encapsulated material concerning beliefs about threat to the self. They concluded that exploring patients' images was a 'particularly effective means of determining core beliefs'. They cite Beck, Laude and Bohnert (1974) as suggesting that 90% of their anxious patients had reported vivid visual images. So making use of imagery in Hypno-REBT may be particularly helpful in unravelling the precise content of an irrational belief.

Evaluative imagery is usually done early in therapy sessions, serving as a format for designing both mental rehearsal and therapeutic interventions. It is also a predictor of the patient’s comprehension of the mechanisms of disease and health, as well as providing a forum for client education.
“Mental rehearsal” is an imagery technique often used before medical techniques or before an anxiety provoking event, usually in an attempt to relieve anxiety, pain, and side effects, which are aggravated by heightened emotional responses (Lascelles, Cunningham, McGrath, & Sullivan, 1989). For example, surgery or a difficult treatment is rehearsed before the event so that the patient is prepared and is rid of any unrealistic fantasies. Normally, a relaxation procedure is taught, then the treatment and recovery period are described in sensory terms as the patient is taken on a guided imagery “journey”. Care is taken to be factual without using emotion-laden or fear-provoking words, and the medical procedure is reframed in a positive way whenever possible. The person is instructed in coping techniques, such as distraction, mental dissociation, muscle relaxation, and abdominal breathing. Published results on clinical mental rehearsal tend to be positive and dramatic. Effects include reduced pain and anxiety, decreased length of hospital stay; less reliance on pain medicines, barbiturates, tranquilizers and other pharmaceuticals; and reduced treatment secondary effects. Mental rehearsal is also central to certain natural childbirth practices. It has been tested as a preparation for spinal surgery; in pelvic examination, endoscopy, cholecystectomy and cast removal; and in burn debridement. In all of these instances, rehearsal through imagery is found to diminish
discomfort, pain, and side effects of medical conditions and treatments (Manyande et al., 1995; Oster, 1994). Whilst this use of imagery may not be elegant, as it usually involves changing the A in the ABCDE model, the process of mental rehearsal through imagery can be used elegantly as in Rational Emotive Imagery.

Imagery as a therapeutic intervention is based on the assumption that the images have either a direct or an indirect effect on health responses (Lascelles et al., 1989). Therefore, either the patients are shown how to use their own flow of images about the healing process or, alternatively, they are guided through a series of images that are intended to soothe and distract them, reduce any sympathetic nervous system arousal, or generally enhance their relaxation. The practitioner may also use “end state” types of imagery, having patients imagining themselves in a state of perfect health, well being, or successfully achieved goals. This intervention would be inelegant from an REBT perspective as it changes the A in the ABCDE model. However, it does have applications for general Hypno-REBT. It can be combined with other “mind-body” approaches. For example, imagery is best known in the treatment of cancer as a means to help patients control pain and mobilise their immune systems, but it is also used as part of a multidisciplinary approach to cardiac rehabilitation and in many settings that specialise in treating chronic pain (Baider,
Uziely, & De-Nour, 1994). In a survey of alternative techniques used by cancer patients and others, imagery is often frequently used (Morrison, Becker, & Isaacs, 1981).

Guided imagery has been used successfully to effect bodily changes (Ahsen, 1968) and to help clients improve doing specific tasks (Morrison & Cometa, 1977). Research findings, which have encouraged the development of imagery as a tool in healthcare, are too numerous to cite. Some of the findings are from well-controlled studies, but the vast majority represents reports of single cases or small studies that have not been replicated. Nonetheless, the overwhelming conclusion is that a relationship between imagery of bodily change and actual bodily change exists. Without question, imagery as a clinical tool and in identifying specific and core irrational beliefs requires further, precise investigation.

A major and serious criticism of most imagery literature and RSDH (as well as hypnosis in general) is that detailed clinic protocols are rarely provided. Hence, it is impossible to know what type of therapeutic strategy was used, and to replicate the study. Whether imagery has the capacity to induce the desired physical effect or is merely an antidote to uncomfortable feelings remains unclear. A review of existing research suggests both conclusions might be justified, depending on the situation under inquiry.
Imagery is not limited to primarily medical and physiological problems. Such “coping imagery” is designed to help the client deal with difficult psychosocial situations, such as making public speeches, living with phobias, or dealing with significant others (Palmer & Dryden, 1995).

An important technique in the arsenal of imagery is **Rational-Emotive Imagery** (REI) which can be used to demonstrate that clients can stand difficult situations and events and how to change unhealthy negative emotions to healthy negative emotions.

The basics of REI were invented in 1971 by Dr. Max Maultsby, after which Ellis modified the procedure. Ellis has claimed that Maultsby’s method overlapped too much with REBT disputing because Maultsby generally had his clients who practiced imagery return to their rational coping statements, which they had previously identified with him, and use them to modify their unacceptable negative feelings when thinking about an unfortunate adversity or Activating Event. Ellis then developed REI as a more emotive-evocative and less disputational method of change (Palmer et al., 1995).

REI is a technique in which a client images him/herself thinking, behaving, and feeling the way he/she wishes to be. This future-oriented imagery can be used to underscore that the client can tolerate and thrive within present adverse circumstances (Lazarus, 1984; Palmer & Dryden, 1995).
Conclusion and call for research

Hypnotherapy is a popular and well known form of therapy. Research has demonstrated its many clinical applications. Hypnosis however is not therapy, rather hypnotherapy is the use of hypnosis in a therapeutic setting. Depending on the therapists' inclination hypnotherapy can be integrative or eclectic.

This dissertation was undertaken to examine the use of hypnosis in REBT and to investigate whether Hypno-REBT could be elegant.

As stated earlier it is likely REBT practitioners will probably have clients requesting hypnosis and hypnotherapists trained in REBT will probably be interested in working elegantly.

Ellis has highlighted a number of similarities between hypnosis and elegant REBT. However, he has in numerous papers described hypnotherapy as inelegant. He attempts to dissuade his clients from hypnotherapy when they ask for it. His reasoning for this appears to stem from how he conceptualises hypnosis in the first place. This is important because the definition and conceptualisation of hypnosis determines its application.

Ellis' conceptualisation is very traditional and is based on the theory of Suggestion. But as already stated many assumptions made in the theory of Suggestion are flawed.
Adhering to one theoretical perspective is generally appropriate and advantageous, however, this is problematic when applied to hypnosis.

There are many theories that attempt to explain hypnosis and hypnotic phenomena. All contain some element of truth and some more so than others. None of them fully and adequately explain it. This dissertation has highlighted the more credible and recent conceptualisations of hypnosis and has disputed the points made by Ellis.

Hypnosis should be conceptualised as a natural and everyday phenomena of consciousness where awareness is heightened. Yapko, 1989, defines it as a process of influential communication. When conceptualised in this way as opposed to Ellis' way, its elegant application becomes apparent.

Enhanced suggestibility is a feature of hypnosis but hypnosis is an active process where the client allows it. Suggestions are accepted if they are relevant and their philosophies understood and agreed with. Suggestibility is enhanced by favourable attitude and mental state. It does not depend on the technique used but on the quality of the relationship between the client and the therapist. Enhanced suggestibility also occurs outside of an induced hypnotic state. For example, it occurs when there is good rapport or a strong therapeutic bond between client and therapist. These states have an important influence on the process of persuasion.
Hypno-REBT can be elegant depending on how hypnosis is conceptualised. Hypnosis is a state of awareness dominated by the subconscious mind (Gullo, 2001). It is that part of the thought process that controls all body functions. It is where beliefs are held. Hypno-REBT can be used to focus on the C of the ABCDE model, or identify the critical A or the specific components of the irrational belief. It can also be useful to dispute irrational beliefs, rehearse and replay events and so on. Because it is emotionally evocative, hypnotic type methods can be an important part of the "emotive" in REBT. Hypnosis enhances the production of imagery and therefore imaginal techniques can be more vivid and emotive. Kroger, (1977) reports that client concentration increases during hypnosis because distractions are excluded and therefore allows the client to focus on a specific idea or scene. Hypno-REBT would make use of self hypnosis in the form of a cognitive homework assignment, not only in assessing the critical A and identifying their irrational beliefs but also in strengthening their rational beliefs, tapping directly into the part of the mind where beliefs are held. Hypno-REBT can also make use of time projection. Korn & Pratt (1998), indicate that hypnotic techniques for imagining the end result 'present a very positive change to behaviour change'.
There are many misconceptions about hypnosis, almost as many as there about REBT. It is the responsibility of the ethical practitioner to deal with such views and offer scientific information.

Both REBT and hypnosis are popular therapeutic tools shown to be useful in a variety of clinical settings. However, rigorous research is still needed to clarify the specific application of elegant Hypno-REBT and their efficacy in clinical psychology. One approach might be to compare groups experiencing elegant REBT with groups experiencing elegant Hypno-REBT and waiting list control groups. Whether Hypno-REBT is better and faster is something to be investigated. In conclusion it is however, important to fulfil client expectancy when seeking hypnotherapy and not attempt to dissuade them. Lazarus (1973) indicated that clients who requested hypnosis and received a standard relaxation sequence that substituted the word relaxation for hypnosis showed more subjective and objective improvements than those who received ordinary relaxation therapy.
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